biological therapy with monoclonal antibodies against selective targets may be a suitable option.
Aim and Objectives To assess the effectiveness and safety in routine clinical practice of omalizumab, mepolizumab and benralizumab in patients with severe uncontrolled asthma.
Material and Methods Retrospective observational study in a regional hospital undergoing patients diagnosed with severe asthma treated with omalizumab, mepolizumab and benralizumab. Effectiveness was assessed based on oral corticosteroid dose reduction, exacerbations and improvement in lung capacity. Safety was demonstrated based on adverse effects onset. Data was obtained from clinical history program and drug dispensing program.
Results 30 patients (53% women) with a median age of 56 years (range: 16–78) have received biological drugs in our hospital to treat severe uncontrolled asthma. 9 patients were treated only with omalizumab, 5 with Mepolizumab, 2 with benralizumab; 7 patients sequentially omalizumab→mepolizumab, 5 cases omalizumab→benralizumab and 2 with the three drugs sequentially.

52% of patients on omalizumab, 71% of patients on mepolizumab, and 78% on benralizumab experienced a decrease in oral corticosteroid dose. Regarding exacerbations: 65% omalizumab, 85% mepolizumab and 78% benralizumab reduced the number of exacerbations. Improvement in lung capacity as a function of Forced Expiratory Volume in 1 second (FEV1) was observed in 74% of patients on omalizumab, 79% on mepolizumab, and 89% on benralizumab. Adverse reactions occurred in 5 cases treated with omalizumab: arthralgia (2), headache, tiredness, cough; 2 cases with benralizumab: skin rash, nasal congestion; and one case of hypertension with the administration of mepolizumab.
Conclusion and Relevance Treatment with omalizumab, mepolizumab and benralizumab in severe asthma is effective in most patients under normal clinical practice conditions. The frequency of adverse effects is low, being mild in most cases, so they can be considered safe drugs.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of Interest No conflict of interest

5PSQ-128 THROMBOPROPHYLAXIS IN THE EMERGENCY DEPARTMENT. ADEQUACY OF THE PRESCRIPTION

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10.1136/ejhpharm-2023-eahp.459

Background and Importance In Europe, the VITAE study estimates an annual incidence of venous thromboembolic disease (VTD) of 243/100,000 inhabitants.

About 25% of VTD cases are related to hospital admissions and 50–75% of VTD cases occur in non-surgical hospitalised patients. PRETEMED is a validated thrombotic risk (TR) scale for clinical prediction that have been designed to be used in daily clinical practice. As well, it is recommended to assess the bleeding risk (BR) with another validated scale called IMPROVE scale before starting thromboprophylaxis (TP).
Aim and Objectives Determine the (TR/BR) and analyse whether the prescription of thromboprophylaxis in patients from the Emergency Department who are going to be admitted to the hospital ward is adequate.
Material and Methods Prospective observational cohort study, carried out in a 2nd level hospital during a period of 10 days. Adult patients in the ED awaiting admission to the hospital ward were included.

Patients with therapeutic effort limitation, COVID-19 patients, those who had been transfused in the last 48 hours, bleeding patients or those with underlying pathology that require anticoagulation were excluded. Using the PRETEMED/IMPROVE scales, the TR/BR was determined, as well as the indication of thromboprophylaxis.
Results 62 patients. 31 women (50%). The median age [range] was 71 [18–93] years. 31 patients with TP regimen, no interventions had to be performed, they had an adequate indication with PRETEMED> 4 and IMPROVE <7. 31 patients without TP regimen; 7 (23%) of them had indication for TP and they went into the operating room with PRETEMED> 4 and IMPROVE <7. 7 (11.3%) of the patients required pharmaceutical intervention to adequate their TP, all of them by default.
Conclusion and Relevance The prescription of TP in adults who visit the ED could be considered adequate in a high percentage, however it can be optimised according to the PRETEMED and IMPROVE guidelines. It is essential to recommend on the use of scales that assess TR/BR for the correct decision-making in the prescription of TP. The limitation of the study was the small sample size.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of Interest No conflict of interest

5PSQ-130 OFF-LABEL USE OF CIDOFOVIR INTRALESIONAL INJECTIONS IN EXTENSIVE ANOGENITAL CONDYLOMATOSIS: A CASE REPORT

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10.1136/ejhpharm-2023-eahp.460

Background and Importance Genital warts caused by human papillomavirus (HPV) in condylomatosis often show a variable response to recommended therapies, especially in immunocompromised patients. New alternatives to improve their approach are needed.
Aim and Objectives To describe the effectiveness, safety, and preparation of cidofovir intralesional injections (ILI) for the treatment of HPV condylomatosis in an immunocompromised patient.
Material and Methods We describe the case of a 33-year-old woman with a giant perianal condylomata accuminata (affecting the clitoris, labia majora and minora, vagina, anal canal and both nalgae). She was initially immunocompromised due to a renal transplant (no renal graft at the starting of cidofovir) and a late-detected common variable immunodeficiency. Condylomatosis precipitated several episodes of bacterial cellulitis. The patient had been previously treated with liquid nitrogen, podophyllotoxin, imiquimod 5%, sinecatechins and 5-fluorouracil, obtaining no response.

Off label treatment with monthly cidofovir ILIs for cytoreductive purposes was proposed and approved. Response to cidofovir ILIs was assessed by reduction in both the number and size of anogenital warts.

Results Cidofovir ILIs were prepared by diluting a vial of cidofovir 375 mg in 60 ml of 0.9% sodium chloride, obtaining a final concentration of 6.25 mg/ml. Of these 60 ml, 5 syringes of 12 ml were loaded (75 mg of cidofovir in each one), which have a stability of 5 months refrigerated (2–8°C), according previous studies.

Intralesional cidofovir treatment started in February 2022. After three drug administrations, a significant improvement in lesions was described by a reduction in both their volume and extension. A bad odor of superficial exudate was also reported, which was solved with first polymyxin and later fusidic acid, both administered topically, twice a day. The patient presented good tolerance to injections, only requiring local anesthesia with lidocaine for pain.

Conclusion and Relevance This is the first case of use of this formulation of cidofovir ILIs in a patient with anogenital condylomatosis and immune deficiency. Previously, it was used in other manifestations of HPV infection. The formulation also proved to be stable, well-tolerated, and easy to prepare. Therefore, this therapy may be considered a reasonable option for the treatment of HVP condylomatosis when other treatments seem ineffective.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

5PSQ-131 LETERMOVIR, GANCICLOVIR AND IMMUNOGLOBULINS COMBINATION TREATMENT IN AN IMMUNOCOMPROMISED PATIENT WITH CYTOMEGALOVIRUS INFECTION: A CASE REPORT

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10.1136/ejhpharm-2023-eahp.461

Background and Importance Cytomegalovirus (CMV) is one of the most common pathogens in immunocompromised patients. Patients who develop severe CMV infection should be treated with antiviral agents until symptoms are resolved and plasma CMV load is controlled. Management of these patients is sometimes difficult due to resistance or ineffectiveness.

Aim and Objectives To describe the response to combined treatment with letermovir, ganciclovir and anti-CMV immunoglobulins (Ig) for CMV infection in an immunocompromised patient refractory to monotherapy treatments.

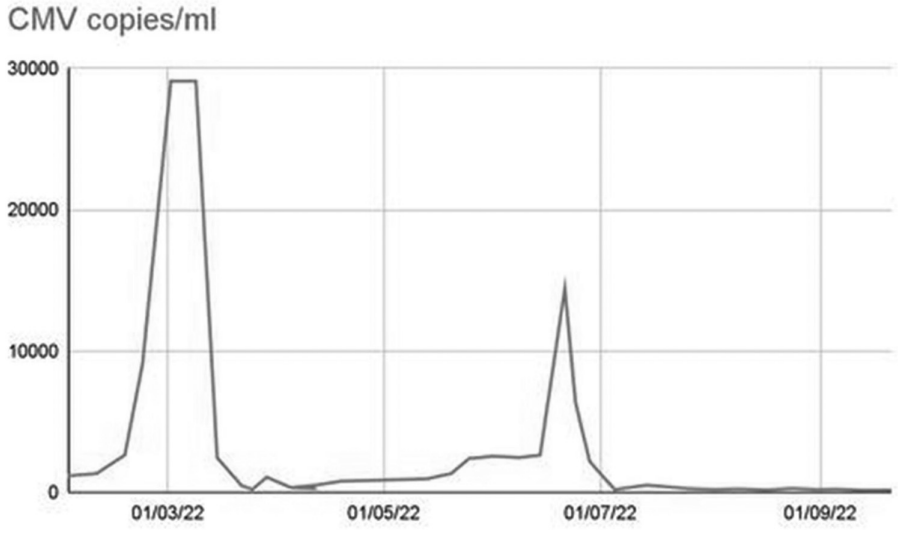
Material and Methods We describe the case of a 72-year-old male diagnosed with Good's syndrome (thymoma-associated immunodeficiency), who developed enterocolitis and systemic infection by CMV. Initially, treatment with IV ganciclovir produced clinical and virological response, but later relapse occurred and resistance to ganciclovir was detected. IV Foscarnet was initiated, obtaining response. After switching to oral letermovir (secondary prophylaxis) having low plasma CMV levels, the patient showed virological failure and foscarnet therapy was reinitiated. After a transient response, foscarnet proved to be insufficient (alone or in combination with ganciclovir) to stop a progressive rise in CMV plasma levels. To control CMV and facilitate intravenous to oral switch, combined treatment with oral letermovir and IV ganciclovir was proposed, added to anti-CMV Ig that the patient was already receiving monthly since the onset of CMV infection.

Effectiveness of this triple therapy was assessed by reduction of CMV plasma load.

Results When absence of letermovir resistance was confirmed, combined off-label use of letermovir, ganciclovir and anti-CMV Ig was approved. The authorisation was based on the absence of therapeutic alternatives and the support of several cases reflecting the good results of this triple therapy.

Despite an initial peak in CMV viral load, triple therapy exhibited a good virological response (CMV <1000 copies/ml) and tolerance. No renal or bone marrow toxicity was detected. IV Ganciclovir was later replaced by valganciclovir for home treatment, maintaining low levels of CMV <300 copies/ml.

Conclusion and Relevance This is the first case of letermovir-ganciclovir-antiCMV Ig combined therapy in a patient with acquired immune deficiency. Previously, it was used in a small cohort of transplant patients. Therefore, this triple therapy should be considered as a possible therapeutic



Abstract 5PSQ-131 Figure 1